Jim Doyle
Governor

WISCONSIN REGULATORY DIGEST

A Newsletter of the
DENTISTRY EXAMINING BOARD

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Mission: "To protect the dental health and well being of the public and facilitate access to safe and adequate dental care for all citizens of Wisconsin"

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FOREIGN TRAINED DENTIST EVALUATION PROGRAM - UPDATE

The Wisconsin statutes 447.04 (1)(b) and Wis. Admin. Code DE 4.02 stipulate that evaluation programs for graduates from dental education programs in other countries outside the United States shall be approved by the Wisconsin Dentistry Examining Board (WDEB). After a comprehensive study of the issue, the Board has decided on an evaluation program that both protects the public and allows foreign trained dentists a pathway for licensure in Wisconsin. At the March 1, 2006 meeting of the WDEB, the members voted to require that besides the other components necessary for licensure, foreign trained dentists will be required to either attend an accredited (by the Commission on Dental Accreditation) dental school in the United States or Canada for a minimum of 2 years and have graduated with a doctor of dental surgery or a doctor of dental medicine degree or attend an accredited (by the Commission of Dental

Accreditation) in a country other than the United States or Canada and have graduated with a degree from that school. The process of promulgating a rule to implement this evaluation has begun and in the interim, the Board has initiated an emergency rule to implement it.

THE ANESTHESIA RULE AND TITRATION

The following is an excerpt from a letter written by the Dentistry Examining Board to the Senate Health Committee relating to the titration portion of its pending rule that revises the anesthesia regulations:

Pertaining to **titration**, the DEB, at its January 11, 2006 meeting, revisited the subject and the following summary articulates the process and the rationale used in arriving at the Board's final decision:

Several of the members of the DEB are active in organizations that interact with dental examining boards from other states. Three years ago, it was brought to our attention by board members from other states that the vast majority of state boards had either recently enacted rules or were in the process of writing rules concerning oral conscious sedation. At the same time, several of our members attended an annual meeting of dental state boards that included a day long lecture and discussion on this topic. At that session, proposed regulations and rules were presented. Most of the members of the DEB are members of our respective professional associations and are familiar with articles and position papers regarding the regulation of anesthesia.

The ADA Current Policies as posted on the ADA website includes this language:

State Regulation

State dental boards have a responsibility to ensure that only dentists who are properly trained, experienced, and currently competent are permitted to use conscious sedation, deep sedation and general anesthesia within their jurisdictions. For this reason, the Association strongly urges state dental boards to regulate dentists' use of these modalities. In addition to identifying educational requirements which are consistent with the Association's Guidelines, state dental boards should evaluate and certify dentists who apply to administer conscious sedation, deep sedation and/or general anesthesia to ensure that the protocol, procedures, facilities, drugs, equipment and personnel utilization meet acceptable standards for safe and appropriate delivery of anesthesia care.

The DEB was also aware of an increase in the numbers of Wisconsin dentists practicing oral conscious sedation. Most of these dentists learned the procedures through a course offered by a relatively new organization (Doctors for Oral Conscious Sedation) which was founded by two general dentists from the east coast who were teaching this technique through a two day course, often given over a weekend. The DEB had received formal complaints about the method of advertising for this service, specifically the use of the term "sleep dentistry." Steps were taken to prohibit that type of unprofessional advertising. In investigating these complaints, individual members of the DEB, assigned to the complaints, reviewed patient records. During the course of that review, cases were discovered where the administration of the medication was not in accordance with professional standards and placed patients at an increased risk.

The DEB studied conscious sedation and titration further and brought an expert, Dr. Joe Best, from Marquette School of Dentistry to address the Board. He informed the Board that Marquette does not teach titration procedures, that no dental school in the United States teaches titration procedures, and that the dental literature does not support titration protocols for oral conscious sedation. He explained that titration of oral drugs was not effective, difficult to assess proper dosage and placed patients at an increased risk of an adverse outcome.

Representatives from the Doctors for Oral Conscious Sedation (D.O.C.S) organization were invited to speak to the DEB. They explained their protocols concerning titration and provided manuals that participants in the course received. A considerable portion of the course was devoted to marketing and explaining how a dentist using conscious sedation could profit from it. Emphasis was placed on the use of titration to obtain longer appointments lengths and in turn, increase profits. Since that time, additional states have enacted rules pertaining to conscious sedation. The D.O.C.S. course currently has less emphasis on marketing/profits in response to these new rules yet they still strongly advocate the use of titration.

In addition, the Board looked at the position of the American Dental Association (ADA) concerning titration. This topic is controversial and that controversy is reflected in the language included in this section of the ADA Guidelines for the Use of Conscious Sedation, Deep Sedation and General Anesthesia for Dentists as published on the ADA website:

> Titration – the administration of small incremental doses of a drug until a desired clinical effect is observed. *In accord with this particular definition, the clinical effects of titration of oral medication for the purposes of sedation are unpredictable. Repeated dosing of orally administered sedative agents may result in an alteration of the state of consciousness deeper than the intent of the practitioner. Except in unusual circumstances, the maximum recommended dose of an oral medication should not be exceeded.*

Also posted on the ADA website is the Primer on "Sedation Dentistry," summarized below:

> Dental boards have expressed concerns with this technique because while the "sedation dentistry" technique may not lead to an unintended deeper level of sedation, unintended consequences can occur through improper dosing. This is because the body absorbs the sedative agents at different rates and additional doses may be prematurely administered to a patient who has not fully absorbed the initial dose thereby compounding the effect. When full sedation is realized, or when the patient reaches peak effect, the patient may then progress into a deeper level of sedation than the dentist intended. This may even occur after the procedure is completed and the patient is at home.
>
> Further concerns were expressed given a dentist's education and training directly relating to the anesthesia permit they can legally apply for and maintain. With different levels of sedation privileges require different levels of necessary advanced education and training, and additional requirements for personnel, facilities and equipment. Dentists who do not have the necessary level of education and

training may be putting patients at unintended risk. The dentist may have planned, and was legally permitted, only to have the patient reach a minimal level of sedation, yet the patient, through repeated doses of oral sedative agents (titration), may progress into a deeper level of sedation, for which the dentist may not have the necessary education, emergency equipment or training to manage.

Additional concerns involve the reversal agents for the technique. In a recent article, ADA spokesman on anesthesia, Dr. Joel Weaver explained his concerns with the effectiveness of reversal agents like Flumazenil in the case of an overdose. "While it is true that Flumazenil given intravenously would be effective in reversing much of the sedative effects of Triazolam-like oral sedative drugs in an emergency," Dr. Weaver explained, "there is no published scientific evidence that it is effective when given by any route other than by intravenous injection." The article further explained, "Even then, there is no data to suggest that it would work fast enough, even if it did eventually work, to rescue a patient from hypoxic brain injury."

Given this background research, our first draft of this proposed rule prohibited titration completely, similar to existing rules in Ohio and Florida. In response to our public hearing, where concerns were raised about the inability of practitioners to maintain satisfactory conscious sedation levels, the DEB revisited the subject of titration.

Further research revealed the following quotes from members of the committee that developed the ADA language on titration:

Dr. Robert Peskin, chair of the Council on Dental Education and Licensure's Committee on Anesthesiology at the time the policy was adopted, explained its purpose. "The concern the ADA had was not with the concept of oral conscious sedation. . . The concern was with the titration of orally administered sedative agents, which could cause a deeper level of sedation than that which was intended by the practitioner."

ADA Committee on Anesthesiology member Dr. Mary George stated, "The guidelines do not prevent anyone from using oral conscious sedation. It doesn't say you can't give a second dose - it says titrating is difficult. Titrating in this manner may leave you with a situation where you've gone over the maximum recommended dose, which is something the guidelines say you shouldn't do."

Dr. Joel Weaver, further explained, "It's not to say that dentists shouldn't give oral sedation. The ADA guidelines indicate that the practitioner should avoid the unintended loss of consciousness, and giving multiple oral doses with short time intervals in between has a greater potential to produce that effect."

We wrote new language allowing dentists to give multiple doses at a single appointment allowing for professional judgment and yet protecting the safety of our dental consumers.

The first part of this new language states that the dentist should wait long enough for the first dose of oral medicine to have an affect, before a second dose is given.

Based on our review of patients' records, sufficient time was often not allowed for that dose to take affect before giving more medication. A second, third or even a fourth dose was given before the first dose had been given enough time to have an affect. This illustrates the ADA's concerns of multiple doses given too closely together to achieve the necessary level. This information on the time needed to reach peak plasma level is published, easily obtained, based on sound research and reviewed by the FDA in the approval process of all drugs.

The second portion of the new language clarified the rule that dentists not exceed the maximum recommended dose of medication in a single day which is also included in the ADA recommendations. This dosage information is also part of the FDA approval, published and easily obtained.

Critics of this part of the rule wish to include in the language that a dentist should not exceed the maximum recommended dose *except in unusual circumstances.*

The DEB deliberated and discussed this issue at great length. It is our belief that this rule should not be written with a loophole to include possible extenuating circumstances. While such language might be proper in an association guideline or recommendation, it is not proper for a rule of this sort. If this rule is written with the language "except in unusual circumstances, then who would define what 'unusual circumstances" are and in effect "unusual circumstances" could apply to any circumstance. This language would so weaken the rule to make it unenforceable. We strongly believe that the existing language allows dentists to administer multiple doses of oral conscious sedation medications in a safe manner utilizing their professional judgment. For the above reasons, the Board voted at our last meeting to retain the existing language, thereby <u>not</u> including the "except unusual circumstances" provision.

SARGENTI TECHNIQUE

The Wisconsin Dentistry Examining Board has received and processed complaints of Endodontic treatment resulting in post-operative pain and failure due to improper instrumentation, irritating paste and obteration of the root canal. The use of the Sargenti technique is below the minimally acceptable standard of practice for Endodontic treatment. The Dentistry Examining Board has jurisdiction in this matter and the use of the Sargenti technique will constitute a violation of the Wis. Admin. Codes DE 5.02 (5).

CPR REQUIREMENTS FOR DENTISTS AND DENTAL HYGIENISTS

CPR is required by Chapter DE 5.02 (24) in Wisconsin Statutes and Administrative Code Relating to the Practice of Dentistry and Dental Hygiene. Chapter DE 5, Standards of Conduct are rules adopted pursuant to ss. 15.08 (5), 227.11 and 447.07 (3).

It reads: (24) Failing to hold a current certificate in cardiopulmonary resuscitation unless the licensee has obtained a waiver from the board based on a medical evaluation documenting physical inability to comply. A waiver shall be issued by the board only if it is satisfied that another person with current certification in CPR is immediately available to the licensee when patients are present.

- Current certificate is training documentation from American Heart Association (renewal is once every two years), Red Cross (renewal is once a year) or other Board approved courses as determined by the Board.
- The level of CPR recommended* is:

- Am. Hrt. Assoc.: Healthcare Provider
- Am. Red Cross: Healthcare Professional

*Note: recommended – not required – all levels are acceptable.

On-line CPR that does not provide any classroom, hands-on / instructor-led skill training and assessment is NOT acceptable.

Credential holders (dentists and dental hygienists) are expected to maintain their own CPR training records. If an investigation of a credential holder occurs – these CPR records may be requested and if available must be provided.

Dental assistant, lab technicians are unlicensed professionals and not required to meet this CPR requirement (the same is true for receptionists, office managers, etc.)

A protective barrier for the provision of mouth-to-mouth resuscitation during CPR is required in a dental office for those employees covered by the OSHA Bloodborne Standard. Examples include bag-to-mouth resuscitation devices, CPR pocket masks, or positive pressure oxygen.

Mock emergency review, readily available emergency phone number, easily accessible telephones, highly visible address on the outside of the office, oxygen tank and an available back board may also be considered for proper response to potential emergency situation.

DISCIPLINARY ACTIONS

Disciplinary summaries are taken from orders that can be reviewed on the Department of Regulation and Licensing Web site: http://drl.wi.gov/index.htm. Click on "Discipline/Orders." Under “Reports of Decisions.” You can either search by name, or use "Reports for the Current Year" or “Prior Years” to access an order. Please note that the Orders are subject to court review, and discipline may be stayed pending an appeal. Progress of cases in court may be reviewed at www.courts.state.wi.us. Current license status may be verified under "Lookup License Holders" on the Department’s website.

The summaries below are drafted by members of the Board. The Dentistry Examining Board views the Digest not only as an announcement of disciplines, but also as an educational tool for our license holders.

JAMES A. MICHAELS DDS
OCONOMOWOC, WI
LIMITED/FORFEITURE/COSTS

On December 18, 1998, while performing root can therapy on a patient, the endodontic file that Dr. Michaels was using broke off in tooth #9. Dr. Michaels was unable to remove the endodontic file and, therefore was unable to fully debride the canal and complete the root canal therapy. The patient was not referred to an endodontist to attempt to remove the retained portion of the endodontic file and to complete debridement of the canal. The patient subsequently developed sensitivity in the area of the tooth #9. Dr. Michaels was ordered to attend and satisfactorily complete a minimum of 10 hours of courses in the performance of root canal therapy. Forfeiture of $400 and costs of $1,825.73. Effective 5/4/05. Violated s. 447.07(3)(h), Wis. Stats. LS0505043DEN

RICHARD L. VANDER HEYDEN DDS
GREEN BAY, WI
REVOCATION, COSTS

In December of 1988, Dr. Vander Heyden started providing dental care to Patient KP and continued to provide dental care to her for about 8 years. Patient KP is trained as a registered nurse. She has an associate degree in Registered Nursing and a bachelor's degree in Psychology and Human Development. Patient KP saw Dr. Vander Heyden to see if she was reacting to the resin fillings in her teeth. Dr. Vander Heyden told Patient KP that he felt she was reacting to the resins, and that the resins

needed to come out. Eventually, he replaced the resin fillings with an intermediary restorative material (IRM). His plan was to restore her teeth with pure porcelain cast material. At various times during the time period relevant to the Complaint filed in this matter, Dr. Vander Heyden used an EAV (electro-acupuncture according to Voll) device in his dental practice that was referred to either as the "Dermatron" or as the "Intero". Both machines measure skin resistance and both are used to perform EAV testing. The Intero is a computer system that has information stored in it and also has measuring capabilities. The Dermatron is just a measuring device. EAV is a general term that describes the procedures and theories behind the use of EAV devices. Part of Dr. Vander Heyden's initial examination of Patient KP, in December of 1988, included the use of an EAV device to see if Patient KP had an autonomic system response to the resins in her mouth. When asked to describe a regular visit with Dr. Vander Heyden, Patient KP stated that most of the time he checked her, using the Dermatron, to find out if she was reacting to anything. In reference to medications, Patient KP said that Dr. Vander Heyden prescribed mostly homeopathic remedies that he made up using the Dermatron. Patient KP described the Dermatron as a machine that is "kind of like a box" that has a computer screen. Dr. Vander Heyden held a metal object in his hand that he used "like a probe" on her fingers. Patient KP stated that Dr. Vander Heyden made up homeopathics "off of the Dermatron" to treat her. Dr. Vander Heyden used a box to put onto the Dermatron machine, and then made the homeopathics by transferring the energy off of it into a glass bottle that contained water. In addition to making the homeopathic remedies using the Dermatron, Dr. Vander Heyden also used a "black box" to make the homeopathic remedies. Patient KP stated that Dr. Vander Heyden informed her that "you put a bottle of just water on one side, and then you put in like a vial of the homeopathic to whatever you have on the other, and then the energy transfers from one to the other. And that makes up the homeopathic basically like it does on the Dermatron, only without the machine". Homeopathic remedies, such as the ones that Dr. Vander Heyden used to treat Patient KP, are available in the form of "prepared solutions" or they may be made through a "serial dilution process". The serial dilution process involves taking a "mother tincture solution" and adding one part of that solution to nine parts of water and re-diluting or repeating the process until the desired potency is obtained. During at least two office visits, Dr. Vander Heyden "balanced" Patient KP's spleen. Dr. Vander Heyden told Patient KP that he was putting energy into that area so it would help whatever problem that organ was having. On one occasion, Dr. Vander Heyden balanced Patient KP's spleen with the probe from the Dermatron. That provided a small "shock". On another occasion, Dr. Vander Heyden balanced Patient KP's spleen by placing his hands quickly around the spleen area. On that occasion, Dr. Vander Heyden told Patient KP that he was directing energy to that spot. Other organs that Dr. Vander Heyden "balanced" using the Dermatron or his hands, during office visits, included Patient KP's lungs, throat and colon. At some point in time during Dr. Vander Heyden's treatment of Patient KP, he used an EAV device to diagnose and treat her for botulism, pneumonia, meningitis and hepatitis. In January 1989, Dr. Vander Heyden provided treatment to Patient KP for bacteria and viruses. Dr. Vander Heyden, using the Dermatron, found evidence of klebsiella (bacteria), staphylococcinum (bacteria), coxsackie (virus) and cytomegalovirus (virus). Dr. Vander Heyden then made up homeopathics "off of the Dermatron" to treat them. On February 6, 1989, Dr.

Vander Heyden, using the Dermatron, found evidence that Patient KP had coxsackie (virus), Epstein-Barr virus, E. Coli, and klebsiella (bacteria). Using the Dermatron, Dr. Vander Heyden gave Patient KP homeopathics to treat the viruses and bacteria. On February 10, 1989, Dr. Vander Heyden, using the Dermatron, diagnosed Patient KP as having Pertussin (whooping cough) and treated her with homeopathic remedies that he made. On May 25, 1990, Dr. Vander Heyden, using the Dermatron, diagnosed Patient KP as having cholecystitis (inflammation of the gallbladder), chronic cholecystitis nosode, and colonitis (inflammation of the colon). Dr. Vander Heyden then gave Patient KP homeopathic remedies that he made on the Dermatron to treat those conditions. On September 10, 1998, B... D... [Patient BD] saw Dr. Vander Heyden for evaluation of his dental condition and preparation of a proposed treatment plan. Dr. Vander Heyden used an EAV device on Mr. D... [Patient BD] to diagnose the existence and cause of systemic disorders, and to prepare a substance for Mr. D... [Patient BD] to ingest to treat the conditions. As of April 20, 2004, the Food and Drug Administration (FDA), had issued only one 501K clearance for a Dermatron device. That clearance was granted to Raymar Electronics (England, UK) in 1989, for use of the, "Dermatron Skin Resistance Meter". The Dermatron approved by the FDA is classified as a "galvanic skin response measurement device". A galvanic skin response measurement device is defined by the FDA to mean "a device used to determine autonomic responses as psychological indicators by measuring the electrical resistance of the skin and the tissue path between two electrodes applied to the skin". Based upon guidelines issued by the FDA, the device is intended only for the measurement of skin resistance. The device should not be used for the diagnosis or treatment of any medical condition and is not approved by the FDA for such usage. The EAV devices (the Dermatron/Intero) used by Dr. Vander Heyden to treat Patient KP have not been approved by the FDA for the diagnosis or treatment of systemic disorders or allergies. The EAV devices (the Dermatron/Intero) used by Dr. Vander Heyden to treat the patient have not been approved by the FDA for the diagnosis or treatment of systemic disorders or allergies. Dr. Vander Heyden knew or should have known that the EAV device that he used was not approved for the uses to which he put it in treating Patient KP. In July 2003, the Complainant, Division of Enforcement, served a Subpoena Duces Tecum ("Subpoena") on Dr. Vander Heyden in which the Division requested that Dr. Vander Heyden appear before Atty. Polewski on August 18, 2003, to answer questions relating to his treatment of Patients KP and BD. The Division also requested in its Subpoena, dated July 15, 2003, that Dr. Vander Heyden produce documents for inspection and copying. On or about August 15, 2003, Dr. Vander Heyden informed the Division that he would not participate in an interview, but that he would provide written information within ten days. Full costs. Effective 7/13/05. Violated s. DE 5.02 (3), Wis. Adm. Code, s 447.07 (3)(f), Stats., 447.07 (3)(a), Stats.

RANDALL H. STRAUB DDS
SUN PRAIRE, WI
REPRIMAND, FORFEITURE, COST

K.K.L., the patient had received general dental services from the Dr. Straub from 9/29/87. On 4/28/99, Dr. Straub commenced orthodontic treatment for the patient. Prior to commencing the orthodontic treatment, Dr. Straub obtained bitewing x-rays on 4/2/98 and a Panorex x-ray on 6/11/98 and had last examined the patient's teeth for dental caries and cleaned the patient's teeth on 10/7/98. Dr. Straub retained responsibility for the patient's general dental care throughout the time that the

patient was receiving orthodontic treatment from him. On 5/11/01, the Dr. Straub removed the bands on the mandibular braces and, on 12/4/01, he removed the bands on the maxillary braces. Dr. Straub obtained Panorex x-rays on 12/29/99 and 2/23/00 but did not perform any general dental examination of the patient's teeth for dental caries or other dental pathology at any time between 4/28/99 and 12/4/01. On 6/21/02, the patient returned to Dr. Straub's office for dental hygiene services and for a general dental examination. Dr. Straub obtained bitewing x-rays and performed the general dental examination. His examination disclosed dental caries on various surfaces of 15 of the patient's teeth. Another dentist who provided a second opinion for the patient confirmed numerous dental caries and performed the necessary restorative work including root canal therapy on tooth #14 and tooth #27. Dr. Straub is ordered to successfully complete an 8 hour course in orthodontic treatment and treatment planning. Forfeiture of $750 and costs of $2200. Effective 7/13/05. Violated s. DE 5.02(5) Wis. Admin. Code. LS0507133DEN.

HOWARD JAY LUBIN DDS
GREEN BAY, WI
LIMITED, SUSPENSION, FORFEITURE, COSTS

In 1996 and 1997, the Division of Enforcement received complaints that Dr. Lubin had practiced negligently with respect to several endodontic patients. On or about September 5, 2001, the Dentistry Examining Board issued a Final Decision and Order in Case Nos. 96 DEN 104, 97 DEN 009, 97 DEN 012 and 97 DEN 061, pursuant to a stipulation of the parties, which limited Dr. Lubin's license to practice dentistry in Wisconsin in several respects. Pursuant to the Final Decision and Order, Dr. Lubin was required to submit to quarterly reviews of his endodontic work. Every three months, he was required to provide to a Board-appointed Monitor a list of all patients examined or treated by him for endodontic problems in the previous three months. The Monitor would then select patients from this list and review the patient records. On or about September 10, 2003, the Department of Regulation and Licensing received a complaint from patient R.M. that Dr. Lubin had negligently performed a root canal on him in June and July, 2003. In particular, R.M. complained that Dr. Lubin had left one root canal (the distal-buccal root canal) unfilled, and that the other two root canals (the mesial-buccal and palatal roots) were under-treated and only partially filled or obturated with root canal filling material. In response to an inquiry by the Division of Enforcement regarding the patient's care, Dr. Lubin claimed that his Touch 'N Heat appliance had failed during the procedure and that he told the patient he would have to return to complete the procedure. The patient states that he was told by Dr. Lubin that the root canal treatment was finished and that he should proceed to have the tooth crowned. On or about October 28, 2003, the Department of Regulation and Licensing received a complaint from patient B.L. that Dr. Lubin had negligently performed a root canal on her in July and August of 2003. In particular, B.L. complained that Dr. Lubin had opened her tooth on four different occasions without completion of the root canal, and that she had sustained a gross mesial wall perforation, a retained, separated endodontic instrument in the distal root and she had a distinct apical radiolucency indicative of an infection. In response in an inquiry by the Division of Enforcement regarding the patient's care, Dr. Lubin stated that he did not believe that he had perforated the tooth, and that although he broke an endodontic file in the patient's root, he recovered that instrument on the next visit. However, the tooth was perforated, and a portion of an endodontic file was present in the tooth after B.L.

terminated care with Dr. Lubin. The parties agree that endodontic files can separate in teeth during root canals through no fault of the dentist. Dr. Lubin did not report to his Monitor having done any endodontic work on patients R.M. or B.L. as required by the September 5, 2001 Dentistry Examining Board Order. Dr. Lubin's 2001 Board Order required him to "list all patients examined or treated by him for endodontic problems in the previous three months" and report those cases to his monitor. Dr. Lubin had not reviewed the Order for several years and erroneously believed that he was only required to report completed root canal therapy cases to his mentor. During the course of this investigation, the Division of Enforcement requested certified copies of all treatment records from May 1, 2003 to the present for patient R.M. In response to the Division's request, Dr. Lubin produced incomplete treatment records for R.M. Dr. Lubin's license to practice dentistry in the State of Wisconsin is LIMITED such that he shall not perform any endodontic procedures. The license of Howard J. Lubin to practice dentistry in the State of Wisconsin is SUSPENDED for a period of one year, commencing 45 days from the date that this Order is signed. Following the period of suspension, Dr. Lubin may return to the practice of dentistry with the LIMITATION described above. Dr. Howard J. Lubin shall participate in and satisfactorily complete a course in record keeping within one year of the date on which this Order is signed. Dr. Howard J. Lubin shall participate in and satisfactorily complete a course in ethics for dentists within one year of the date on which this Order is signed. Dr. Howard J. Lubin's dentistry practice will be monitored both for quality of care and for type of care provided, for two years following the completion of his suspension. Forfeiture of $5000 and costs of $9000. Effective 7/13/05. Violated s. 447.07(3)(a), 447.03(h), 447.07(3)(n), Wis. Stats. And s. DE 5.02(5), DE 5.02(7), DE 5.02(17), and DE 5.02(25). LS0409232DEN.

DANIEL L. DRIES DDS
BEAVER DAM, WI
SURRENDER/COSTS

Dr. Dries is under investigation, but desires to retire from practice for personal reasons. Costs of $2000. Effective 7/13/05. LS0507132DEN.

RAYMOND L. SCHNEIDER DDS
GREEN BAY, WI

On June 28, 1995 a patient visited Dr. Schneider's office complaining that he could not chew his food with his existing dentures. Dr. Schneider examined the patient, made some adjustments to his dentures and suggested dental implants as a potential treatment option. On 9/11/95, Dr. Schneider performed surgery to place four implants in the patient's mandible. On 10/19/95, the Dr. Schneider examined the patient and noted that the implants demonstrated some tenderness and lateral micro mobility. Dr. Schneider attached a hadar bar to the implants and on 10/23/95 loaded the implants by inserting the lower denture with a soft reline over the implants. The patient returned for follow-up visits on 11/7/95, 1/8/96 and 3/12/96. The implants continued to demonstrate lateral micro mobility. The patient continued to complain of difficulty chewing his food. On 3/12/96, Dr. Schneider noted the presence of a fibro-osseous connection. An x-ray taken by Dr. Schneider on 3/26/96 showed a radiolucency on the right. The patient's continuing complaints, the results of Dr. Schneider's examinations and the dental x-ray demonstrated that the implants had failed by 3/12/96. The patient continued to return to Dr. Schneider on a regular basis for evaluation of the dental implants through 7/21/98. The patient was unable to return to Dr. Schneider's office between 7/21/98 and 9/9/99 due other unrelated

health issues. Dr. Schneider's last examination of the patient was on 9/9/99. Dr. Schneider suspected at that time that the implants may have failed and may need to be removed. The patient was scheduled for removal of the hadar bar and further examination on 9/29/99. Corrective repair and removal was planned as needed. The patient cancelled the appointment and scheduled an appointment with another dentist. On 10/22/99 the patient was examined by another dentist who determined that the implants had failed and that the adjacent tissue was infected. He recommended removal of the implants. The implants were removed by this dentist on 11/4/99 following a course of antibiotics. Dr. Schneider is ordered to satisfactorily complete 50 hours of course work in implants and prosthetics before resuming implant dentistry including but not limited to the placement of implants and the fabrication or placement of prosthetic devices utilizing implants. His practice of implant dentistry will be monitored for 2 years. Forfeiture of $500 and costs of $15,000. Effective 9/28/05. Violated Wis Stats. 447.07(3)(a) and Wis. Admin. Code DE5.02(5). LS0411244.

KENNETH R. SACHTJEN DDS
MADISON WI
SURRENDER

Between September 4, 1998 and September 14, 1998, a patient went to Dr. Sachtjen's office to have bridge work tightened. Without taking any x-rays and without performing a thorough examination of the patient's teeth, Dr. Sachtjen told the patient that root canals were needed on all four abutment teeth before his bridge could be placed back on them. Over the course of two visits, Dr. Sachtjen did the root canals and bridgework on the patient. Dr. Satchjen charged the patient $7,000 for the work. Between March and May of 2001, the patient went back to see Dr. Satchjen. Dr. Satchjen determined, without an examination of the patient's teeth, that she needed to have crowns and root canals on two teeth. Dr. Satchjen did the root canal work on the patient's teeth using a modified version of the Sargenti Technique. Soon after Dr. Satchjen placed crowns on the patient's teeth, the patient became dissatisfied with the comfort of the crowns. In addition, the bridge that Dr. Satchjen put in the patient's mouth became loose. The patient went to Dr. Satchjen and tried to talk to him about the problems she was having with his work. However, Dr. Satchjen dismissed the patient's concerns. In March of 2002, the patient then went to a subsequent treating dentist. This dentist took x-rays of her mouth and found, among other things, a fractured bridge, crowns with severe overhangs and several root canals that were poorly done and incomplete. All of this dental work had been performed by Dr. Satchjen. Effective 9/28/05. Violated Wis State Stats. 447.07(3)(h). LS0509282.

DALE FALK DDS
SULLIVAN WI
REPRIMAND, FORFEITURE,COSTS

On August 14, 2000, Dr. Falk restored teeth I, J, K and L on an eight year old patient. Dr. Falk did not use anesthetic. On August 21, 2000, Dr. Falk restored teeth A, B, S, and T on the patient again without anesthetic. On August 21, 2000, the restoration fell out of tooth T. On August 22, 2000, Dr. Falk replaced the restoration that had fallen out of tooth T. On September 19, 2000, the patient complained of a tooth ache to his parents, who gave him Tylenol, which they noted seemed to help. On September 20, 2000, the patient again complained of tooth pain. On September 21, 2000, Dr. Falk's receptionist told the patient's parent that Dr. Falk could not see the patient until September 25, 2000. On September 23, 2000, a different dentist, examined the patient and noted that the cavity in the

tooth I extended to the pulp chamber. He further diagnosed that tooth A was missing a two surface amalgam restoration, and that the restorations on teeth K and L were loose. On October 11, 2000, that dentist removed defective restorations Dr. Falk had placed in teeth K, L, S, and T and replaced them. Ordered to satisfactorily complete 6 hours of education in pediatric dentistry and 6 hours of education in restorative dentistry. Forfeiture of $500 and costs of $2375.22. Effective 9/29/05. Violated Wis. Stat. 447.07(3)(h). LS0411243

PETER HEHLI DDS
APPLETON, WI
REPRIMAND, LIMITED, FORFEITURE, COSTS

In December of 1998, Dr. Hehli fabricated an anterior bridge that was less than minimally competent in that it had open margins, tissue impingement because of over contouring, bridge margins short of the prepared margins on teeth #9 and #11, and esthetic errors of contour and shade. On another patient Dr. Hehli extracted tooth number 29 on May 22, 1998, and placed a two unit bridge on the patient on July 3, 1998, using tooth number 28 as an abutment; tooth number 30 was present, with a crown, but was not used as an abutment for the bridge replacing tooth #29. Tooth number 28 required endodontic therapy on August 6, 1998, and Dr. Hehli used the Sargenti technique in that effort. Dr. Hehli is prohibited from using the Sargenti technique. Forfeitures of $500 and costs of $4618.83. Effective 11/2/05. Violated DE 5.02(5) Wis Admin. Code. LS0404271DEN.

ALESSANDRO SAVAGLIO, JR DDS
KENOSHA WI
REPRIMAND, FORFEITURE, COSTS

On three occasions between May 1, 2001 and July 12, 2002, Dr. Savaglio filed insurance claims for dental services provided to a patient. The insurance claims contained inaccurate representations about services provided to the patient, resulting in overpayment for services actually provided. On two occasions between November 28, 1998 and January 30, 2002, Respondent provided dental treatment to a patient. Dr. Savaglio filed insurance claims containing inaccurate representations about services provided to the patient, resulting in overpayment for services actually provided to the patient. Forfeiture of $500 and costs of $2,060. Effective 1/11/06. Violated Wis Stat. 447.07(3)(k). LS0508312.

MARK A. NELSON DDS
OREGON, WI
REPRIMAND, LIMITED, COSTS

Dr. Nelson gave an employee an affectionate hug and tried to kiss her on her mouth. Then he put his hand on one of her breasts over her clothing. He then pulled her blouse away from her body as though he was going to reach under it and asked “may I?” she responded “No” and pulled away. Dr. Nelson is ordered to complete the STOP program. He shall practice under the supervision of a dentist approved by the Board. Costs of $750. Effective 1/11/06. Violated Wis. Stat. 447.07(3)(f). LS0601111DEN.

BLAIR D. MOLDENHAUER DDS
SUN PRAIRIE, WI
SUSPENSION

The Board received evidence of a positive drug screen result which constitutes a violation of a previous Final Decision and Order.

Wisconsin Department of Regulation and Licensing
Dentistry Examining Board
P.O. Box 8935
Madison, WI 53708-8935

DENTISTRY EXAMINING BOARD DIGEST

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